Pharmacy

Prior Authorization Criteria for Butrans (Buphrenorphine transdermal system)

Background

Butrans (Buphrenorphine transdermal system) is a transdermal formulation of buprenorphine indicated for the management of moderate to severe chronic pain in patients requiring a continuous, around-the-clock opioid analgesic for an extended period of time. At its August, 2011 meeting the DoD Pharmacy and Therapeutics (P&T) Committee voted to recommend prior authorization criteria for Butrans.

The following criteria were established by the DoD Pharmacy & Therapeutics (P&T) Committee:

Prior Authorization Criteria for Butrans (Buphrenorphine transdermal system)

All current and new users of Butrans (Buphrenorphine transdermal system) must meet one of the following criteria in order for coverage to be approved:

1. Coverage provided for patients ≥ 18 yrs with moderate to severe chronic pain requiring opioid therapy.
    a. Opioid naïve patients (prior use of < 30 mg/day of morphine or equivalent in past 60 days) are limited to Butrans 5 mcg/hr patch.
    b. Opioid tolerant patients (prior use of 30 mg/day to 80 mg/day of morphine or equivalent in past 60 days or Butrans 5 mcg/hr patch) can receive Butrans 10 mcg/hr.
    c. Maximum dose of Butrans is 20 mcg/hr.

2. Coverage is NOT provided for treatment of opioid dependence.

3. Coverage is NOT provided for patients:
    a. Requiring > 80 mg/day of morphine or equivalent for pain control.
    b. With significant respiratory depression or severe bronchial asthma.
    c. With long QT syndrome or family history of long QT syndrome.
    d. On concurrent Class 1A (procainamide, quinidine) or Class II (defetilide, amiodarone, sotalol) antiarrythmics.

Criteria approved through the DoD P&T Committee process

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Defense Health Agency,
a component of the Military Health System
DHHQ, 7700 Arlington Blvd,
Falls Church, VA 22042

Butrans (buprenorphine)
Prior Authorization Request Form

5653

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) or the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: **TpharmPA@express-scripts.com**

Prior authorization criteria and a copy of this form are available at: **http://pec.ha.osd.mil/forms_criteria.php.** This prior authorization has no expiration date.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is Butrans being used for the treatment of opioid dependence?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to Question 2
2. Is Butrans being used to treat moderate to severe chronic pain requiring opioid therapy?	☐ Yes Proceed to Question 3	☐ No **STOP** Coverage not approved
3. Is the patient 18 years of age or older?	☐ Yes Proceed to Question 4	☐ No **STOP** Coverage not approved
4. Are any of the following true: • **patient requires more than 80 mg/day of morphine or equivalent for pain control?** • **patient has significant respiratory depression or severe bronchial asthma?** • **patient with long QT syndrome or family history of long QT syndrome?** • **patient is on concurrent Class 1A (procainamide, quinidine) or Class III (dofetilide, amiodarone, sotalol) antiarrythmics?**	☐ Yes **STOP** Coverage not approved	☐ No Proceed to Question 5
5. Is the request for the Butrans 5 mcg/hr patch?	☐ Yes Please sign and date below	☐ No Proceed to Question 6
6. Is the patient opioid tolerant (prior use of 30 mg/day to 80 mg/day of morphine [or equivalent], or Butrans 5 mcg/hr patch, within the past 60 days)?	☐ Yes Please sign and date below	☐ No Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

Implementation: 4 Jan 2012